Rose Isabel Williams Mental Health Reform Act of 2020

Status Report
October 1, 2022 – December 31, 2022

MS Department of Finance and Administration
Office of the Coordinator of Mental Health Accessibility

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Abstract

This report is submitted pursuant to MCA § 41-20-5(h) and the *Rose Isabel Williams Mental Health Reform Act of 2020* which implemented a comprehensive review and report on Mississippi's mental health system to assess the structure, funding, adequacy, delivery, and availability of services throughout the State. The report covers the period of October 1, 2022, through December 31, 2022. The report provides an overview of the 988 suicide prevention and crisis support system; a review of crisis residential services (capacity, admissions and reasons persons are not admitted); an update on available capacity and admissions at DMH-Operated Psychiatric Hospitals; an update on the progress towards OCMHA's recommendation for Coahoma, Quitman, Tallahatchie, and Tunica Counties to join Region 6 CMHC and the dissolution of Region 1 CMHC; an update on Region 11 CMHC regarding status of operations; a summary of recommendations and progress to date for improved crisis services under development at Region 11 CMHC; a review of workforce salaries amongst CMHCs; and OCMHA Recommendations for Q4 2022.

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Quarterly Status Report
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OCMHA has included the following topics for the fourth quarter report:

- 988 Suicide Prevention and Crisis Support System
- Crisis Residential Services (CRS): Capacity, Admissions, and Reasons Persons Are Not Admitted
- DMH-Operated Psychiatric Hospitals' Capacity and Admissions
- Follow-up to OCMHA Q3 2022 Status Report Recommendation for Coahoma, Quitman, Tallahatchie, and Tunica Counties to Join Region 6 CMHC and for the Dissolution of Region 1 CMHC
- Update on Region 11 CMHC Regarding Status of Operations
- Improved Crisis Services Under Development at Region 11 CMHC
- CMHC Workforce Salaries
- OCMHA Recommendations

988 Suicide Prevention and Crisis Support System

The United States had one death by suicide every 11 minutes in 2020. During the past year, 4.9 percent of adults 18 or older had serious thoughts of suicide and among adolescents 12 to 17, 12 percent had serious thoughts of suicide and 2.5 percent attempted suicide. Death by suicide is designated as the second leading cause of death for ages 10-14 and 25-34 (HHS.gov).

During 2020, Congress passed the 988 National Suicide Hotline Designation Act of 2020. The Act directed states to create statewide coordinated crisis services systems with adequate and stable funding. In 2021, the Mississippi Department of Mental Health (DMH) was awarded $125,000 (Mississippi Department of Mental Health FY 2021 Annual Report) by Vibrant Emotional Health, the administrator of the National Suicide Prevention Lifeline and 988 State Planning Grant, to begin laying the foundation for the transition and implementing community outreach.

As of July 2022, 988 became the national three-digit dialing code for the National Suicide Prevention Lifeline (NSPL), hereafter referred to as the Lifeline. Beginning July 2022, callers dialing 988 are routed to the Lifeline across the United States. The creation of a national three-

digit phone number is anticipated to increase access to vital crisis services and help to save lives. Per the current federal law, only Lifeline member centers can receive 988 calls, chats and texts.

Crisis care is transforming into a system that offers a continuum of services, from the initial call to 988, to a response by a mobile crisis team of trained behavioral health professionals, to a location for stabilizing individuals and follow up care (HHS.gov).

Similar to legislation in many states that allows for the collection of fees added to cell phone bills to support 911, the Act allows states to assess a fee on cell phone bills to recover the costs related to the three-digit number and associated crisis services, such as crisis call centers, personnel, and outreach and stabilization services. The fees collected are held in state trust funds and are adjusted for volume and other criteria and implementation and oversight boards provide governance and guidance.

The Act tasked states with creating the path for implementation through legislation, such as financing strategies, designation of an oversight body, defining the types of mobile crisis response teams, and establishing processes for real-time service coordination. The National Association of State Mental Health Program Directors (NASMHPD) developed and distributed a *Model 988 Bill* in 2021 for states to use as a template. Some of the key features of the Model Bill include:

- Definitions of key terms;
- Establishes criteria for state crisis call centers' relationships with NSPL;
- Establishes the importance of chat and text functions;
- Promotes real-time crisis care coordination;
- Encourages specialized crisis services for populations at-risk;
- Establishes criteria for mobile crisis team (MCT) staffing;
- Recommends services staff that reflect the demographics of the community; and
- Encourages enhanced relationships with law enforcement.

NASMHPD reports that about half of states had introduced legislation as of February 2022. A summary of states' progress on legislation, implementation efforts and financing strategies is available at www.nasmhpd.org (Stephenson). Other resources to assist states are available at https://www.nasmhpd.org/content/988-transforming-crisis-systems-resources.

In March 2022, HB732 was approved by Governor Tate Reeves. *See HB 732 attached as Appendix "B."* The law expresses intent to be compliant with the National Suicide Hotline Designation Act of 2020. It requires the creation of a study commission on the 988 comprehensive behavioral health crisis response system that will assess and develop recommendations for crisis response services and describes an intent to adequately fund crisis response services statewide, thus sustaining Mississippi call centers and crisis services. The

commission is comprised of the following members or their designees: the Executive Director of the Department of Mental Health, the State Health Officer or the Deputy Director of the State Department of Health, the Coordinator of Mental Health Accessibility, the Executive Director of the Mississippi Emergency Management Agency, the Commissioner of Public Safety, the Executive Director of the Division of Medicaid, the Chair of the Public Service Commission, the Chair of the Senate Public Health and Welfare Committee or a designee, the Chair of the House Public Health and Human Services Committee or a designee, the Executive Director of the Mississippi Association of Police Chiefs, the Executive Director of the Mississippi Sheriff's Association, the Director of the Mississippi Center for Emergency Services or a designee, and a representative from the Mississippi Ambulance Alliance. The first meeting of the Study Commission was held Tuesday, August 30, 2022, (www.dmh.ms.gov). A summary of the legislation is provided below (legislature.ms.gov):

> *"An Act To Provide Legislative Intent Regarding Compliance With The National Suicide Hotline Designation Act Of 2020 To Assure That All Mississippians Receive A Consistent Level Of 9-8-8 And Crisis Behavioral Health Services No Matter Where They Live, Work Or Travel In The State; To Create The Study Commission On The 9-8-8 Comprehensive Behavioral Health Crisis Response System; To Provide For The Members Of The Study Commission; To Provide That The Study Commission Shall Assess And Develop Recommendations For Crisis Response Services And For Adequately Funding The Crisis Response Services System Statewide To Support The Sustainability Of Call Centers And Crisis Services; And For Related Purposes."*

In 2022, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded nearly $105 million in grant funding to 54 states and territories in advance of the required July 2022 implementation date to aid in the transition. DMH was awarded $693,227. The funds are aimed at: 1) improving response rate; 2) increasing capacity to meet future demand, and 3) ensuring calls initiated are routed to local, regional, or state crisis call centers. The SAMSHA grant may also be used to build the workforce necessary for increasing access to local text and chat response. States are expected to make additional investments where needed to shore up the crisis care continuum. Mississippi has already awarded additional funding made available by the American Rescue Plan Act to increase its capacity.

SAMHSA is monitoring the following associated metrics (SAMHSA):

- Workforce Development: Number of persons trained
- Partnership/collaboration: Number of organizations that entered into formal agreements to improve mental health practices
- Screening: Number of individuals screened
- Referral: Number of individuals referred to mental health
- Access: Number and percent of individuals receiving services after referral

In December 2022, SAMHSA, awarded an additional $47 million to states and U.S. territories to expand and enhance 988 Suicide & Crisis Lifeline services. DMH was awarded $458,333 (SAMHSA). Table 1 provides a summary of funding DMH has received to support 988 (Storr, 2022).

Table 1: Summary of Funding for 988

Source	Type	Amount
SAMHSA Mental Health Block Grant (MHBG) FY 2/1/21 – 9/30/25	Annual grant with federally required minimum 10% set aside to be spent for 988 and Mobile Crisis Response	$1,305,228
SAMHSA MHBG COVID-19 Relief Supplement Funding	Federally required minimum 5% set aside of total award	$377,829.15
ARPA COVID-19 Funding Proposal to MS Legislature for 988	American Rescue Plan Act	$10,000,000
SAMHSA Grant to Build Capacity	Federal Grant	$693,227
SAMHSA Grant Supplemental Award	Federal Grant	$458,333

As of 2021, Mississippi provides primary coverage 24/7 for all 82 counties via two Lifeline centers:

- CONTACT The Crisis Line (Jackson, MS) serves 74 counties
- CONTACT Helpline (Columbus, MS) serves eight (8) counties

These two centers provide backup coverage for one another. Mississippi has consistently achieved high in-state answer rates. The call volume for July 2021-2022 was 18,388. The average in-state answer rate between July 2021 and July 2022 was 90%. Figure 1 shows the number of routed calls that includes all networks (NPSL, Spanish, and VA) for June 2020 - June 2021 and July 2021 - July 2022.

Figure 1: Number of Routed Calls

Time Frame	Number of Calls
June 2020 – June 2021	18,107
July 2021 – July 2022	18,388

People can call or text 988 or chat at 988lifeline.org. Chat and text resources have increased and persons using these functions have increased over the past year as evidenced in a year-over-year comparison for the month of July 2021 and July 2022 illustrated in Figure 2 below. Chat functions saw a 111% increase and text function saw an increase of 285%.

Figure 2: Changes in Chat and Text Frequency for July 2021 and July 2022

	July 2021	July 2022	% Change
Chat	120	253	111%
Text	59	227	285%

Crisis Residential Services (CRS): Capacity, Admissions and Person Not Admitted

All Community Mental Health Centers (CMHCs), with the exception of Region 15 CMHC, provide crisis residential services within their catchment area. According to the DMH *Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Use Community Service Providers,*
crisis residential services are:

> *...time-limited, residential treatment services provided in a Crisis Residential Unit which provides psychiatric supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to people who are experiencing a period of acute psychiatric distress which severely impairs their ability to cope with normal life circumstances. Crisis Residential Services must be designed to prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress and further decomposition. Crisis Residential Services content may vary based on each person's needs but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms.*

Crisis Stabilization Units (CSUs) are designed to accept admissions (voluntary and involuntary) twenty-four (24) hours per day, seven (7) days per week. DMH reports that during FY22, 3,108 people received services at a CSU and 90% were diverted from longer-term, more restrictive inpatient treatment. There are 181 available CSU beds in Mississippi as of November 2022. Table 2 below offers a summary of the available beds at CSUs operated by the respective CMHC regions.

Table 2: CMHC Region Crisis Residential Units and Bed Capacity

CMHC Region	Location	Bed Capacity as of November 2022
Region 1	340 Getwell Drive, Marks, MS	8
Region 2 *	120 Randy Hendrix Drive, Batesville, MS	9
Region 3	1927 B Briar Ridge Road, Tupelo, MS	8
Region 4	1000 State Street, Corinth, MS	16
Region 6	714 Third Street, Cleveland, MS	16
Region 6	1970 Grandview Drive, Grenada, MS	16
Region 7	219 Wood Street, West Point, MS	8
Region 8	725 Brookman Drive, Brookhaven, MS	16
Region 9	4715 Methodist Home Road, Jackson, MS	16
Region 10	700 Northside Drive, Newton, MS	16
Region 11	150 Jefferson Davis Blvd, Natchez, MS	12
Region 12	15120 County Barn Road, Gulfport, MS	16
Region 12	934 West Drive, Laurel, MS	16
Region 14	330- B Highway 90, Gautier, MS	8
Total		**181**

**Region 2 Crisis Residential Unit capacity is normally 16 but the facility is currently completing renovations, so the capacity is cut to nine.*

CSUs are used to improve the outcomes of persons experiencing mental health crises and divert individuals from unnecessary admissions to one of the four DMH-operated state hospital programs. When one of the state hospitals receives a commitment for admission in Mississippi, attempts are made to divert the admission to one of the CSUs.

OCMHA requested and received data from DMH on CSU referrals for FY22. On average, for every 100 persons admitted to the CSUs in Mississippi, an additional 83 persons were not admitted for services. Figure 3 below provides a summary of admissions and persons not admitted by region. Five of the 13 reporting CMHC CSUs did not admit more individuals than were served. Region 1 CMHC had the highest percent of person not admitted (68%) and Regions 8 (27%) and 11 (26%) had the lowest percent of persons not admitted. Region 2 CMHC did not have the data available.

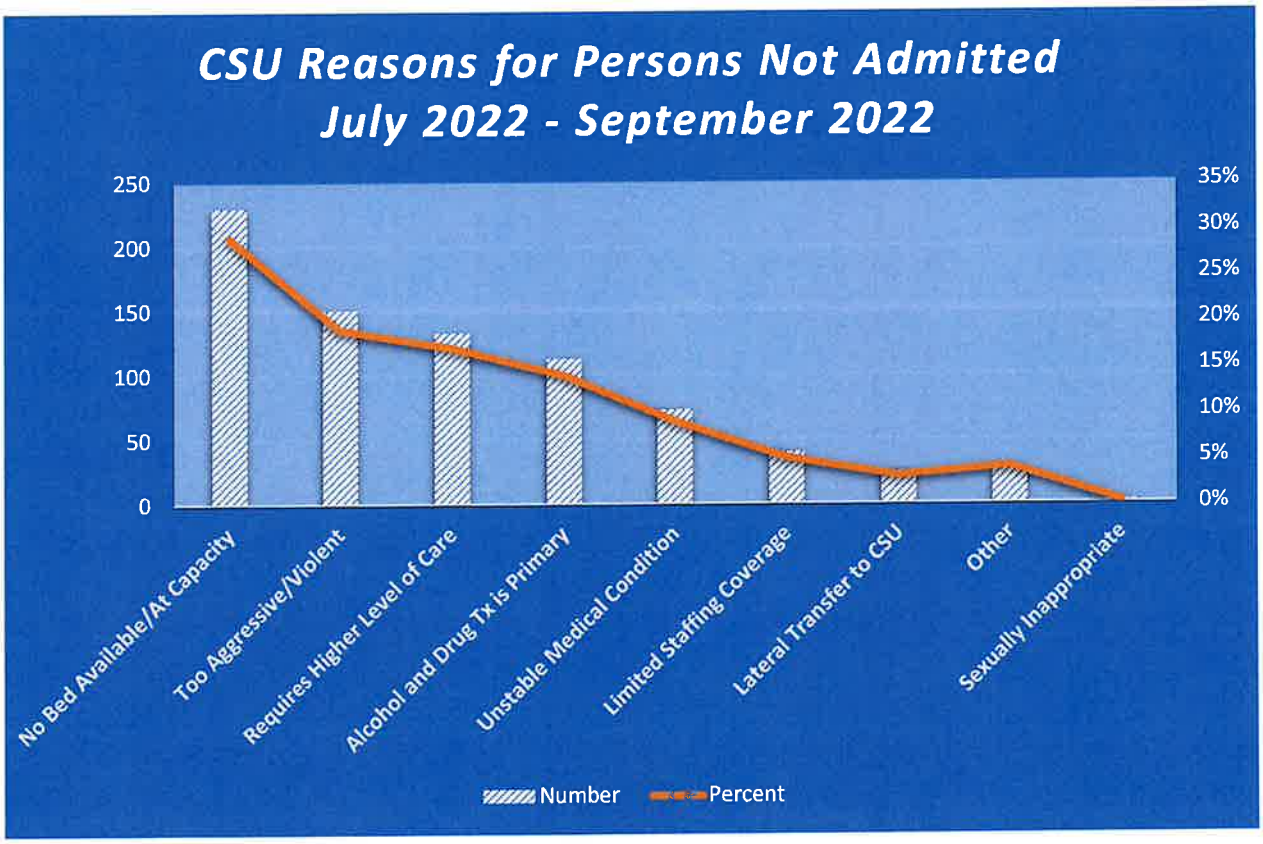
Figure 3: FY 22 CSU Admissions and Persons Not Admitted by Region

CMHC Region	Address	Persons Not Admitted FY 2022	Number Served FY 2022	Percent of Persons Not Admitted
Region 1	340 Getwell Drive Marks, MS	300	142	68 %
Region 2 (Operated by Region 4)	120 Randy Hendrix Drive Batesville, MS	80	167	32%
Region 3	1927 B Briar Ridge Road Tupelo, MS	219	193	53 %
Region 4	1000 State Street Corinth, MS	280	236	54 %
Region 6	714 Third Street Cleveland, MS	235	289	45 %
Region 6	1970 Grandview Drive Grenada, MS	261	215	55 %
Region 7	219 Wood Street West Point, MS	75	124	38 %
Region 8	725 Brookman Drive Brookhaven, MS	113	311	27 %
Region 9	4715 Methodist Home Road Jackson, MS	164	252	39 %
Region 10	700 Northside Drive Newton, MS	277	332	45 %
Region 11	150 Jefferson Davis Blvd Natchez, MS	26	74	26 %
Region 12	15120 County Barn Road Gulfport, MS	154	276	36 %
Region 12	934 West Drive Laurel, MS	419	323	56 %
Region 14	330- B Highway 90 Gautier, MS	83	174	32 %
Total / Average		2686	3108	46 %

For FY 2023, DMH offered enhancement grants for the CSUs aimed at increasing admissions due to security or capacity issues. Each CMHC that operates a CSU received an additional $400,000 and funds could be utilized for any resources or staff that would increase their ability to accept admissions. Each CMHC has the flexibility to determine what their needs are, and items might include nursing staff, alarm panic systems, security staff, etc.

CMHCs are required to report monthly on reasons persons are not admitted. According to the *DMH Cost Reimbursement Grant Data Metrics First Quarter Report*, for the period of July – September 2022, 230 (29%) persons were not admitted because the CSU was at capacity; 151 (19%) persons were not admitted because they were too aggressive/violent; 133 (17%) persons were not admitted because they required a higher level of care; 113 (14%) persons were not admitted because the person had a primary alcohol and drug use disorder; 73 (9%) persons were not admitted because they had an unstable medical condition; 40 (5%) persons were not admitted because the CSU had limited staff coverage; 25 (3%) persons were transferred to a different CSU or lateral transfer; 2 (.25%) persons were not admitted because they were assessed as sexually inappropriate, and 28 (4%) of those not admitted were classified as "other." The overall rate for those not admitted for the quarter was 48%. Figure 4 below illustrates the reasons for persons not admitted and the rates.

Figure 4: CSU Reasons for Persons Not Admitted for July 2022 - September 2022



OCMHA believes that further research is needed on the seemingly large rates of persons not admitted and the impact on access to services. This research project should be a joint collaborative effort between the OCMHA Best Practices Committee, the Mississippi Association of Community Mental Health Centers, and DMH. In OCMHA's review, a wide range of protocols and practices exist across CSUs and increased standardization and agreement amongst CMHCs may serve to strengthen the system of crisis residential services. Options that warrant further consideration include:

1. Clear communication of criteria for admission and working to ensure potential clients and referring agencies are aware of the specific criteria that must be met in or order to meet eligibility for admission to the programs. This increases the chances that referred individuals are appropriate candidates.
2. Comparison of admission policies and criteria across all CSUs and identification of opportunities for standardization.
3. Regular review and update of admission criteria to ensure they are appropriate and reflective of the needs of the population.
4. Expand access to the state psychiatric bed registry system to chancery clerks and first responders. *See OCMHA Status Report for January 1, 2022 – June 30, 2022.*
5. Monitor trends related to being at or near full capacity and expand capacity where warranted to reduce the likelihood of having to turn away clients due to lack of availability.
6. Expansion of alternatives for care by developing relationships with other providers in the community when the CSU is unable to admit an individual.
7. Increase and improve outreach and engagement by CMHCs with individuals and referring agencies (primary care providers, chancery clerks, emergency departments, outpatient mental health clinics, and other law enforcement agencies) to better understand the needs of the community and finding ways to get persons the treatment they need. Such a campaign on the part of the CMHCs may be similar to the Public Awareness Campaign recently launched by DMH, in partnership with Creative Distillery, to disseminate information regarding services provided by Mississippi's crisis response system operated by CMHCs, including 988 and mobile crisis teams, crisis stabilization units, and emergency crisis services; intensive community support services, including Programs of Assertive Community Treatment (PACT) teams and Intensive Community Outreach Recovery Teams (ICORT); supported living services; peer support services; substance use prevention and treatment services; and other services provided by Community Mental Health Centers.

DMH-Operated Psychiatric Hospitals' Capacity and Admissions

DMH-operated psychiatric hospitals offer the most restrictive level of care and are intended to serve as a last resort for individuals involuntarily committed for psychiatric treatment. During the COVID pandemic bed space was reduced to comply with CDC requirements as well as workforce shortages. A comparison of pre-COVID bed capacity illustrates the impact on access. Mississippi State Hospital (MSH), located in Whitfield, saw a low of 65 beds compared to the

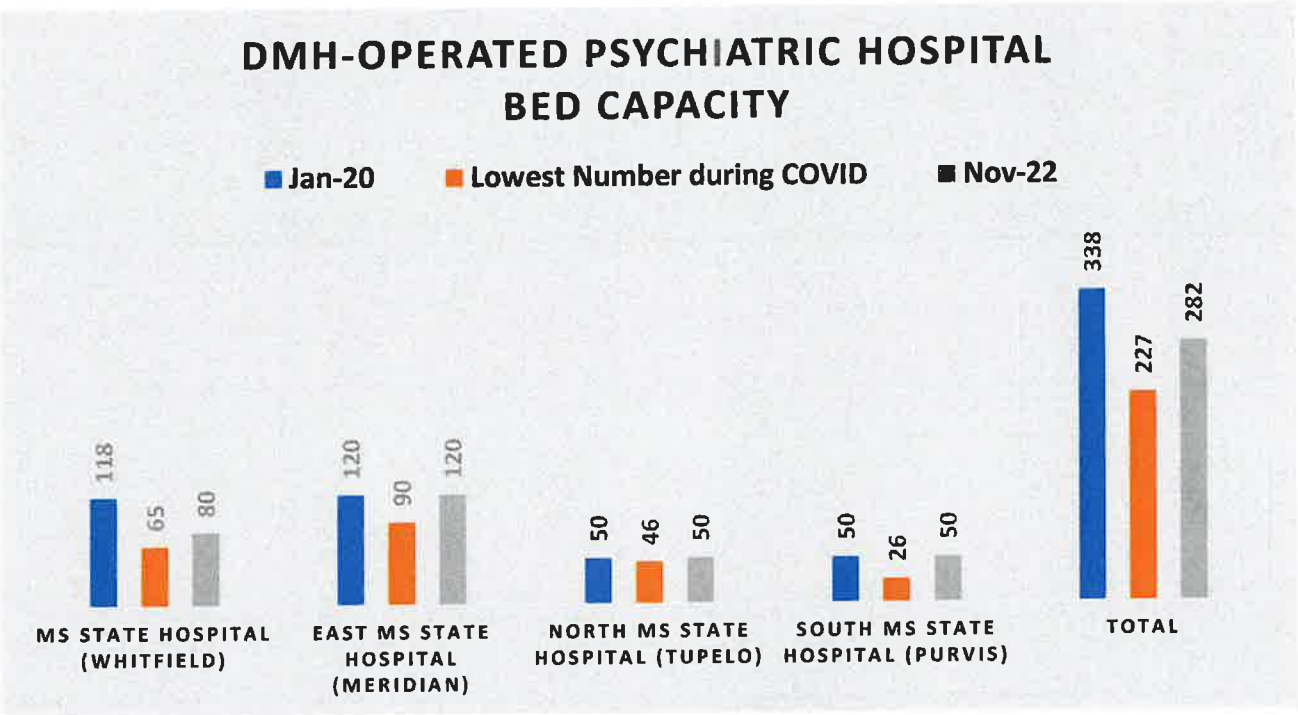
pre-pandemic number of 118. East Mississippi State Hospital (EMSH), located in Meridian, experienced a reduction from 120 to 90; South Mississippi State Hospitals (SMSH), located in Purvis, experienced a reduction from 50 to 26; and North Mississippi State Hospital (NMSH), located in Tupelo, experienced a reduction from 50 to 46.

Hospitals have since worked towards restoring capacity to pre-COVID levels, with all but MSH now back to pre-COVID numbers. EMSH has the largest bed capacity at 120. NMSH and SMSH have the lowest best capacity at 50. MSH experienced a reduction of 38 beds between January 2020 and November 2022, yet served 150 more persons in FY22 than in FY21. EMSH served 113 less patients; NMSH served 71 less; and SMSH served 6 less. Overall, the hospitals served 28 less persons in FY22 than in FY21. Per DMH, MSH's goal is reportedly to increase total beds from 80 to 100 in the very near future. Table 3 below offers a summary of the hospitals and illustrates availability of beds and Figure 5 offers and illustration of progress made towards achieving pre-COVID bed capacity.

Table 3: Summary of DMH-Operated Psychiatric Hospitals Beds and Numbers Served

DMH-Operated Hospital	Number of beds as of January 2020	Lowest Number during COVID	Number of adult beds as of November 2022	Change in beds	Number served FY21	Number served FY22	Change in Number Served
MS State Hospital (Whitfield)	118	65	80	(38)	596	746	150
East MS State Hospital (Meridian)	120	90	120	0	472	359	(113)
North MS State Hospital (Tupelo)	50	46	50	0	497	426	(71)
South MS State Hospital (Purvis)	50	26	50	0	425	431	6
Total	**338**	**227**	**282**	**(38)**	**1,990**	**1,962**	**(28)**

Figure 5: DMH-Operated Psychiatric Bed Capacity



Update on OCMHA Q3 2022 Status Report Recommendation for Coahoma, Quitman, Tallahatchie, and Tunica Counties to Join Region 6 CMHC and for the Dissolution of Region 1 CMHC

Region 1 CMHC currently serves Coahoma, Quitman, Tallahatchie, and Tunica Counties. *See Map of the CMHC Regions and Counties attached as Appendix "B".* OCMHA's *Q3 2022 Status Report* offered financial data that indicated that Region 1 was financially vulnerable with the second lowest cash balance ($791,674) in the state. Based upon financial and service data gathered and discussions with the leadership of Regions 1 and 6, OCMHA determined that mental health services could better be sustained for residents of Region 1 CMHC's catchment area if the counties were served by another CMHC region. Region 6 CMHC presented as the most likely candidate for success based on factors such as consolidation experience, financial stability, and geographic proximity.

Meetings were held with primary stakeholders and on August 24, 2022, the Region 6 CMHC Board of Directors voted to invite the counties currently served by Region 1. OCMHA, along with the Executive Director of Region 1, Karen Corley, and the Executive Director of Region 6, Phaedre Cole, appeared before the Boards of Supervisors in November and asked that a resolution be passed by each of the counties to join Region 6. Boards of Supervisors for all four counties voted unanimously to join Region 6, effective February 1, 2023.

Progress continues to be made on acquiring buildings, contracts, human resources, and other assets and processes and much work remains. The Executive Director of Region 6 CMHC has posted a master list of available positions and persons that were employed by Region 1 can apply for all positions for which they are qualified. All persons who were employed at Region 1 must apply to gain employment with Region 6. Interviews will begin mid-January and orientation for employees will begin later in January. Region 1 was not a member of the state Public Employees Retirement System (PERS) and Region 6 is a member. Employees from Region 1 that Region 6 hires will now be a member of PERS with enrollment to begin on February 1, 2023. After the employee is vested (8 years), they will have the option to "buy back" the number of years they worked at Region 1.

Region 6 CMHC's Executive Director reports that Region 1 and Region 6 utilized different electronic healthcare record (EHR) software. Region 6 staff is working closely with their EHR vendor to add approximately 2000 individuals previously served by Region 1, as well as train approximately 130 staff on the EHR. Some of the buildings in Region 1 are owned and some are leased. Details on the buildings have yet to be determined and this remains a work in progress. Both regions have grants with MS Department of Transportation (MDOT) that assist in funding transportation for individuals served. MDOT transportation grants for the joining counties will continue under Region 6. One significant addition in services that will occur for residents of the joining counties will be the implementation of wraparound services. DMH defines wraparound facilitation as the "creation and facilitation of a child/youth and family team for the purpose of developing a single plan of care to address the needs of children/youth with complex mental health challenges and their families (Mississippi Department of Mental Health)."

Region 6 CMHC has submitted client level data to the Mississippi Division of Medicaid (DOM), which will ensure that there are no gaps in services for individuals or gaps in reimbursements for services provided. DOM is working to ensure prior authorizations are properly transferred. DOM is coordinating efforts with Medicaid managed care organizations to switch any remaining authorized units of service over to Region 6 CMHC rather than requiring re-authorization.

Update on Region 11 CMHC

OCMHA has found that sustainability of operations at Region 11 CMHC is in imminent jeopardy due to factors such as workforce shortages, expiration of federal funding, high employee turnover, and long-standing financial and clinical challenges. Region 11 service area includes Claiborne, Jefferson, Adams, Franklin, Wilkinson, Amite, Pike, Lawrence, and Walthall counties.

OCMHA has been working closely with Region 11 CMHC executive staff since July 2022 to assess the center's financial and clinical struggles, improve their operational performance and identify long-term solutions. The center has been able to maintain operations in recent years

thanks to two Substance Abuse Mental Health Services (SAMHSA) federal grants and COVID-related funding. The federal grants allowed Region 11 to receive reimbursement for services that previously had no pay source and were covered through service fees and general revenue. This provided some financial relief and also supported service expansion. One of the grants lapses in February 2023 and the other will lapse in September 2023. Region 11 was recently awarded an additional federal grant, but it is very specific in nature and will not support continuation of all newly implemented reimbursement practices and service expansion.

Region 11 CMHC is facing high employee turnover. More than 50% of employees leave each year and a lack of employee benefits is believed to be a contributing factor. Out of 117 current employees, only 17 were hired prior to 2020. Anecdotal reports indicate it generally takes three to six months for CMHC staff to achieve satisfactory productivity levels necessary for improving financial stability. Additionally, Region 11 has been offering higher than average compensation to attract staff, which may be unsustainable in the long-term. At some point, the compensation will have to be adjusted to market and doing so will be challenging. The transition may contribute to additional turnover which will likely erode Region 11's chances for success.

In early 2022, the OCMHA identified substantial deficiencies in the delivery of mental health services within Region 11 CMHC to the Boards of Supervisors in the respective counties. OCMHA found that the delivery of mental health services in the counties located in Region 11 failed to satisfy the standards set forth in Miss. Code Section 41-20-5. Accordingly, OCMHA required a plan of correction from each of the respective nine counties. *See OCMHA Quarterly Status Report for July 1, 2021 – September 2021; see also OCMAH Quarterly Status Report for July 1, 2022 – September 2022.* As a result, the Boards of Supervisors hired a consultant in June 2022 to offer recommendations to specifically address the financial needs of Region 11. The consultant made recommendations, including the following: (1) a capital infusion from the counties in the catchment area; (2) increased annual county contributions; and (3) provision of health insurance as an employee benefit. To date, no action has been taken on these recommendations.

Beginning July 2022, OCMHA began meeting collaboratively with the Region 11 CMHC Executive Director and Financial Officer on a weekly basis. These meetings are aimed at assisting and assessing operations and increasing the chances for self-sustaining operational and clinical practices. Priorities have included correcting data, increasing productivity, and resolving service issues related to productivity. Throughout the process, OCMHA has also been working with Region 11 to address delinquent tax payments and develop relationships with community stakeholders such as local law enforcement agencies and schools.

The meetings have included a variety of activities and topics, such as:

1. Increasing the capacity of the financial officer hired in early 2022 to understand how newly implemented electronic healthcare records (EHR) software should function in the context of CMHC operations;
2. Evaluation of fee for service billing trends;
3. Comparison of service data across counties in the Region 11 catchment area;
4. Analysis of revenue and expenditures;
5. Identified multiple data errors resulting from implementation of EHR software implemented in October 2021 where certain parts of the billing module were incomplete;
6. A weekly productivity report of billable revenue hours for each clinician was prepared by the financial officer and reviewed for gaps and opportunities for maximizing billable time;
7. Identification of opportunities to improve scheduling processes and front office data collection;
8. Identification of gaps in collection of payer information for individuals served leading to unreimbursed services or a reduction in efficiency of reimbursement from payers;
9. Identified absence of protocols and practices for collection of co-pays to increase revenue;
10. Evaluation of no-show data that led to improved processes to reduce no-show rates such an open allowing walk-in appointments during certain days and times;
11. Established measurable, realistic productivity goals for staff and monitoring protocols;
12. Identification of gaps in getting timely prior authorizations (PAs) and PA renewals for psychosocial rehabilitation, children's day treatment services and CSU services resulting in lost revenue;
13. Improved processes and monitoring for gaining and renewing PAs in a timely manner;
14. The limitations of DMH grants and the importance of assigning qualified individuals to grant funding to increase revenue for qualified individuals were examined and processes for correction were implemented;
15. Evaluation of the potential impact of the expiration of two federal grants on personnel and operations including the possible elimination of some personnel and transition of other staff to positions supported by fee for service revenue;
16. Budget projections for Region 11 were discussed, highlighting the high (50%+) annual employee turnover, making it difficult for the organization to be self-sustaining from fee for service revenue;
17. Possible sources of working capital, such as mortgaging and selling unneeded real estate were discussed;
18. Status of PERS and tax payments were discussed; and
19. Importance of obtaining MOUs from school districts and developing relationships with law enforcement agencies.

Improved Crisis Services Under Development at Region 11 CMHC

In August of 2022, OCMHA met with Adams County officials and discovered that citizens with serious mental illness and local stakeholders would benefit from improving crisis services in that area. As a result, OCMHA met with Region 11 CMHC Executive Director and requested that the CMHC initiate a meeting between the Adams County Sheriff's Department, Natchez Police Department, and other relevant partners in order to facilitate plans for improving crisis services through the creation of a Crisis Intervention Team (CIT) and single point of entry for Adams County and potentially other counties in the Region 11 service region.

CIT is a nationally recognized best practice proven to be a successful model for law enforcement to respond effectively in situations involving a mental health crisis. A CIT is a collaborative partnership between law enforcement agencies, mental health providers, consumers and family members of consumers. Individuals experiencing a mental health crisis are diverted to appropriate settings that offer treatment, ensuring individuals are not arrested and taken to jail due to the symptoms of their illness. In OCMHA's *Quarterly Status Report for October 1, 2021, through December 31, 2021*, OCMHA recommended that "all CMHC regions pursue and promote the development of CIT" in their service areas.

Creation of the single point of entry would help established the capacity to accept referrals 24 hours a day, seven days a week. The creation of a single point of entry is recommended to be at the Adams County Crisis Stabilization Unit (CSU) so that individuals in crisis referred by the CIT can be screened, assessed, and a plan of care developed. Other anticipated action is CIT training for members of law enforcement and creation of a memorandum of understanding (MOU) between the CIT trained law enforcement and Region 11 CMHC.

CMHC Workforce Salaries

OCMHA recently made a request for information regarding salaries from the CMHCs, and reviewed trends in salaries across CMHC regions on the basis of the information submitted.[1] OCMHA found significant variability in salaries for leadership positions amongst the regions. Table 4 below provides an illustration of average salaries and salary ranges as reported by CMHCs. The average salary for an Executive Director is $154,699, with a range from $74,000 to $381,925. Out of 12 of 13 regions reporting, the average salary for a financial officer is $106,922, with a range from $41,880 to $174,155. Ten regions report a position of Chief Administrative Officer, the average salary is $103,003, with a range from $65,000 to $185,500.

Nine of the 13 regions reported a salary for a Clinical Director position. The average salary is $87,010, with a range of $65,000 to $228,025. Eleven of the CMHCs report a salary for

[1] CMHC workforce salary information for the quarter ended September 30, 2022, was provided by all thirteen CMHC Regions pursuant to a request for information by OCMHA.

psychiatric mental health nurse practitioners. The average salary is $122,223, with a range of $103,935 to $152,200. The average salary for an outpatient nurse is $59,921 with a range of $52,250 to $80,500. For the five regions reporting a pharmacist, the average salary is $139,832, and the range is $128,593 to $163,114.

The average salary, as reported by the CMHCs, for a Master's level clinical staff is $49,590, with a range of $39,932 to $82,500. The number of persons with a Master's who are also professionally licensed clinicians is not available. Professionally licensed master's level clinicians (e.g., LPC, LCSW, LMFT) working in private practice have an average salary of $84,214, according to ZipRecruiter™ (ZipRecruiter, 2023). CMHC leadership also reports a consistent loss of master's level counselors and social workers as criteria are met by employees to obtain professional licensure.

The average salary for persons in positions requiring a minimum of a Bachelor's degree is $33,255 with a range of $27,130 to $47,133. Staff working in positions at CMHCs that require a Bachelor's degree earn $8,383 less on average in Mississippi than a newly started teacher. Figure 6 below offers a comparison of salaries and comparable degrees. *See OCMHA Quarterly Status Report for July 1, 2021 – September 30, 2021.*

Table 4: CMHC Average Workforce Compensation

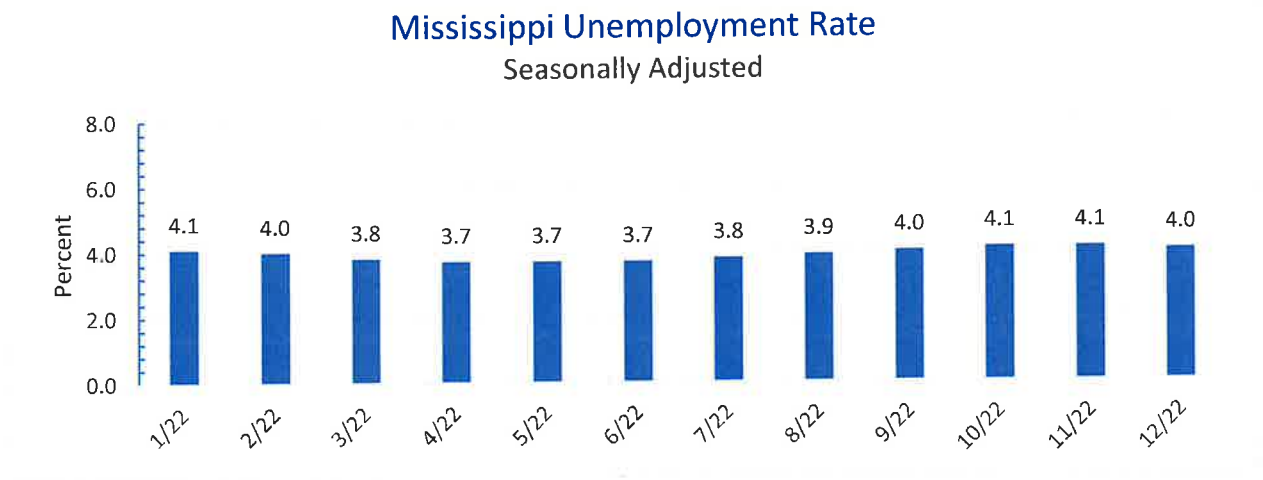
Position	Average	Range
Executive Director	$154,699	$74,000 to $381,925
Financial Officer	$106,922	$41,880 to $174,155
Chief Administrative Officer	$103,003	$65,000 to $185,500
Clinical Director	$87,010	$65,000 to $228,025
Psychiatrist		
Psychiatric Mental Health Nurse Practitioner	$122,223	$103,935 to $152,200
Outpatient Nurse	$59,921	$52,250 to $80,500
Pharmacist	$139,832	$128,593 to $163,114
Master's Level Clinician	$49,590	$39,932 to $82,500
Bachelor's Level Staff	$33,255	$27,130 to $47,133

Another consistent concern was that of entry-level workforce shortfalls in staff aids, van drivers, and other positions that are generally paid at minimum wage or slightly above. CMHC Executive Directors report that they had to increase pay as they were left unable to compete with other options in their communities, such as fast-food restaurants paying $15/hour. One CMHC Executive Director reported that the CSU in the Region had been particularly hard hit with regard to RNs and entry-level tech positions.

Labor Force in Mississippi

OCMHA recently requested data on the general workforce in Mississippi to gain perspective, as CMHCs and other behavioral health programs are still encountering obstacles due to shortages in the workforce. The Mississippi Department of Employment Security provided data on the unemployment rate and the rate of labor participation.[2] The data is computed by all states using U.S. Bureau of Labor Statistics (BLS) definitions and methodology (U.S. Bureau of Labor Statistics, 2023). For 2022, unemployment rates[3] stayed relatively stable while labor participation rates[4] have lowered in Mississippi. The highest percent of participation was 55.3% during February and March 2022 and the lowest in December of 2022 at 54.4%. Figures 6 and 7 below offer illustration and further detail regarding trends. This suggests that there may be a significant number of people who are no longer actively seeking employment and have therefore dropped out of the labor force. The combination of stable employment rates and lowered labor participation rates in Mississippi suggests a complex and potentially challenging labor market, which may impact the ability to recruit and maintain the workforce needed in behavioral health programs.

Figure 6: Mississippi Unemployment Rate January 2022 - December 2022



[2] The Mississippi Department of Employment Security, Labor Market Information is funded by the U.S. Department of Labor, Bureau of Labor Statistics (BLS) to compute Civilian Labor Force data, such as the unemployment rate and labor force participation rate. The data is computed by all states using BLS definitions and methodology.
[3] In the Current Population Survey, people are classified as unemployed if they meet all of the following criteria: they were not employed during the survey; they were available for work during the survey reference week, except for temporary illness; and they made at least one specific, active effort to find a job during the 4-week period ending with the survey reference week OR they were temporarily laid off and expecting to be recalled to their job.
[4] The labor force includes all people age 16 and older who are classified as either employed and unemployed. The labor force participation rate represents the number of people in the labor force as a percentage of the civilian noninstitutional population. The civilian noninstitutional population age 16 and older is the base population group, or universe, used for Current Population Survey (CPS) statistics published by BLS. The civilian noninstitutional population group excludes the following: active duty members of the U.S. Armed Forces; people confined to, or living in, institutions and detention centers and residential care facilities such as skilled nursing homes.

Figure 7: Mississippi Labor Force Participation Rate, Seasonally Adjusted, January 2022 - December 2022

OCMHA Recommendations

Issue: Rates for Patient Admissions and Reasons Not Admitted to CSUs

During FY22, on average, for every 100 persons admitted to the CSUs in MS, an additional 83 people were not admitted for services. Five of the 13 reporting CMHC CSUs did not admit more persons than were served.

Background

CSUs are short-term residential facilities that provide support and treatment to individuals experiencing a mental health crisis. They are typically less restrictive than inpatient psychiatric hospitals and are designed to provide a safe, supportive environment for people to stabilize and recover from a crisis. CSUs typically offer a range of services and support, including individual and group therapy, medication management, and social and recreational activities. They may also offer support with basic needs, such as meals and housing. The length of stay in a CSU can vary, but it is typically shorter than a stay in a psychiatric hospital.

CSUs can be a helpful resource for persons who are experiencing a mental health crisis and need support and treatment in a safe, structured environment. They can provide a steppingstone between inpatient psychiatric care and returning to daily life in the community.

It is appropriate for CSUs to serve persons with SUDs as substance use can often be a factor in mental health crises. CSUs can provide

support and treatment for individuals with SUDs in addition to addressing their mental health needs. Treatment for SUDs may include counseling, medication-assisted treatment (MAT), and support for recovery. By addressing both conditions, CSUs can help individuals stabilize, recover from a crisis and improve their overall well-being.

Recommendation 1: The OCMHA Best Practices Committee, the Mississippi Association of Community Mental Health Centers, and DMH should create a workgroup of state hospital staff, CMHC staff and other parties (local hospitals) to do the following:

1. Work to create Memorandums of Understanding (MOUs) between local CSUs and local hospitals to create a solution for individuals needing medical treatment.
2. Explore reasons persons were not admitted and identify solutions for persons who meet criteria for admission.
3. Explore admission policies and procedures for identification of reasons persons were not admitted.
4. Explore impact of workforce shortages and identify solutions for workforce recruitment, training and retention.
5. Create a path direct path to provide crisis services for person with substance use disorder (SUD) as these individuals may be at high risk for imminent harm due to overdose.
6. Create a direct path to provide brief intervention and referral to treatment for persons in crisis.
7. Other issues identified by the workgroup.

Issue: Region 11 CMHC Crisis Response Services

Region 11 CMHC lacks CIT training for law enforcement, associated MOUs with CIT trained law enforcement officers and single points of entry for persons experiencing a mental health crisis referred by CITs.

Background

In OCMHA's *Quarterly Status Report for October 1, 2021, through December 31, 2021*, OCMHA recommended that "all CMHC regions pursue and promote the development of CIT" in their service areas.

CIT has proven to be a successful model for law enforcement to deal with situations involving individuals with serious mental illness. A CIT is a community partnership among a law enforcement agency, a community mental health center, a hospital, other mental health providers, consumers and family members of consumers. Officers who have received crisis intervention training respond to individuals

experiencing a mental health crisis and divert them to an appropriate setting to provide treatment, ensuring individuals are not arrested and taken to jail due to the symptoms of their illness. CITs are a nationally-recognized best practice, and officers who have received CIT training have been recognized as having the understanding and skills needed to resolve crisis situations.

As a result of on-site assessments and community feedback, OCMHA recommended Region 11 CMHC prioritize improved response to mental health crisis and response.

§ 41-21-135. Oversight of Crisis Intervention Teams by community mental health centers; collaborative agreements among community health center, law enforcement agency and hospital that will serve as single point of entry.

(1) Community mental health centers shall have oversight of Crisis Intervention Teams operating within their service areas.

§ 41-21-143. Active encouragement of hospitals and law enforcement agencies to develop Crisis Intervention Teams and comprehensive psychiatric emergency services.

(1) Community mental health center directors shall actively encourage hospitals to develop comprehensive psychiatric emergency services. If a collaborative agreement can be negotiated with a hospital that can provide a comprehensive psychiatric emergency service, that hospital shall be given priority when designating the single point of entry.

(2) The State Department of Mental Health shall encourage community mental health center directors to actively work with hospitals and law enforcement agencies to develop Crisis Intervention Teams and comprehensive psychiatric emergency services and shall facilitate the development of those programs.

Recommendation 1	Region 11 CMHC should partner with local law enforcement to create and train CITs and establish formal MOUs between the CMHC and CIT law enforcement officers for all counties in the service region.
Recommendation 2:	Create single points of entry for Adams County as well as for all other counties in the region for persons referred by CITs.

Appendix A

House Bill 732

MISSISSIPPI LEGISLATURE

REGULAR SESSION 2022

By: Representatives Felsher, Mickens

To: Public Health and Human Services

HOUSE BILL NO. 732

AN ACT TO PROVIDE LEGISLATIVE INTENT REGARDING COMPLIANCE WITH THE NATIONAL SUICIDE HOTLINE DESIGNATION ACT OF 2020 TO ASSURE THAT ALL MISSISSIPPIANS RECEIVE A CONSISTENT LEVEL OF 9-8-8 AND CRISIS BEHAVIORAL HEALTH SERVICES NO MATTER WHERE THEY LIVE, WORK OR TRAVEL IN THE STATE; TO CREATE THE STUDY COMMISSION ON THE 9-8-8 COMPREHENSIVE BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM; TO PROVIDE FOR THE MEMBERS OF THE STUDY COMMISSION; TO PROVIDE THAT THE STUDY COMMISSION SHALL ASSESS AND DEVELOP RECOMMENDATIONS FOR CRISIS RESPONSE SERVICES AND FOR ADEQUATELY FUNDING THE CRISIS RESPONSE SERVICES SYSTEM STATEWIDE TO SUPPORT THE SUSTAINABILITY OF CALL CENTERS AND CRISIS SERVICES; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. For the purposes of this act, the following words and phrases shall have the meanings as defined in this section, unless the context clearly requires otherwise:

(a) "National Suicide Prevention Lifeline" or "NSPL" means the national program that operates the national suicide prevention and mental health crisis hotline system;

(b) "9-8-8" means the universal telephone number for the national suicide prevention and mental health crisis hotline system;

(c) "9-8-8 crisis hotline center" means a state identified and funded center participating in the National Suicide Prevention Lifeline Network to respond to statewide or regional 9-8-8 calls;

(d) "SAMHSA" means the Substance Abuse and Mental Health Services Administration;

(e) "Mobile crisis response teams" include behavioral health professionals and peers that provide professional onsite community-based intervention such as de-escalation, stabilization, etc., for individuals who are experiencing a behavioral health crisis.

SECTION 2. It is the intent of the Legislature to:

(a) Save lives by improving access to appropriate services and supports to respond to behavioral health crises;

(b) Comply with the National Suicide Hotline Designation Act of 2020 and the Federal Communication Commission's rules adopted on July 16, 2020, to assure that all Mississippians receive a consistent level of 9-8-8 and crisis behavioral health services no matter where they live, work or travel in the state;

(c) Authorize the State Department of Mental Health to designate 9-8-8 crisis hotline center(s) that shall:

(i) Have an active agreement with the administrator of the NSPL for participation within the network;

(ii) Meet NSPL requirements and best practices guidelines for operational and clinical standards;

(iii) Report and participate in evaluations and related quality improvement activities;

(iv) Use technology, including chat and text, that is interoperable across emergency response systems used throughout Mississippi;

(v) Deploy crisis and outgoing services, including mobile crisis response teams, and coordinate access to crisis receiving and stabilization services and other local resources as appropriate and according to guidelines and best practices established by the NSPL;

(vi) Meet the requirements set forth by NSPL for serving high-risk and specialized populations as identified by SAMHSA, including training requirements and policies for transferring hotline callers to an appropriate specialized center or subnetworks within, or external to, the NSPL network;

(vii) Provide follow-up services to individuals accessing the 9-8-8 hotline consistent with guidance and policies established by the NSPL; and

(viii) Provide to the State Department of Mental Health and SAMHSA, as required, an annual report of the 9-8-8 suicide prevention and behavioral health crisis hotline's usage and the services provided;

(d) Appropriate the funds needed for the first year of 9-8-8 implementation and to make additional investments to enhance the crisis response system; and

(e) Maintain access to a statewide crisis system of care that is interconnected, effective and ensures a culturally and linguistically competent response to behavioral health crises.

SECTION 3. (1) There is created the Study Commission on the 9-8-8 Comprehensive Behavioral Health Crisis Response System to assess the statewide crisis response system and make recommendations to:

(a) Remove barriers to access behavioral health crisis services;

(b) Ensure that all residents receive a consistent and effective level of behavioral health crisis services no matter where they live, work or travel in the state;

(c) Adequately fund the crisis response services system statewide to support the sustainability of call centers and crisis services, looking at ongoing funding by Medicaid, federal and state revenue, or other funding sources;

(d) Propose strategies and policies for ongoing coordination with 911 and law enforcement; and

(e) Propose strategies for supporting investment in new technology to triage calls and link individuals to follow-up care.

(2) The study commission shall be comprised of the following members:

(a) The Executive Director of the State Department of Mental Health or his or her designee;

(b) The State Health Officer or the Deputy Director of the State Department of Health;

(c) The Mental Health Accessibility Coordinator or his or her designee;

(d) The Executive Director of the Mississippi Emergency Management Agency or his or her designee;

(e) The Commissioner of Public Safety or his or her designee;

(f) The Executive Director of the Division of Medicaid or his or her designee;

(g) The Chair of the Mississippi Public Service Commission or his or her designee;

(h) The Chair of the Senate Public Health and Welfare Committee or his or her designee;

(i) The Chair of the House Public Health and Human Services Committee or his or her designee;

(j) The Executive Director of the Mississippi Association of Police Chiefs;

(k) The Executive Director of the Mississippi Sheriff's Association;

(l) The Director of the Mississippi Center for Emergency Services or his or her designee; and

(m) A representative from the Mississippi Ambulance Alliance.

(3) The Study Commission shall meet within sixty (60) days after the effective date of this act, upon call of the Executive Director of the State Department of Mental Health, and members of the study commission shall meet at least two (2) times per year.

(4) Members of the commission shall not receive any compensation for serving on the commission.

(5) The study commission shall receive reports and updates from the 9-8-8 Planning Coalition and shall consult with the 9-8-8 Planning Coalition to obtain any information necessary to perform a comprehensive study of the statewide crisis response system.

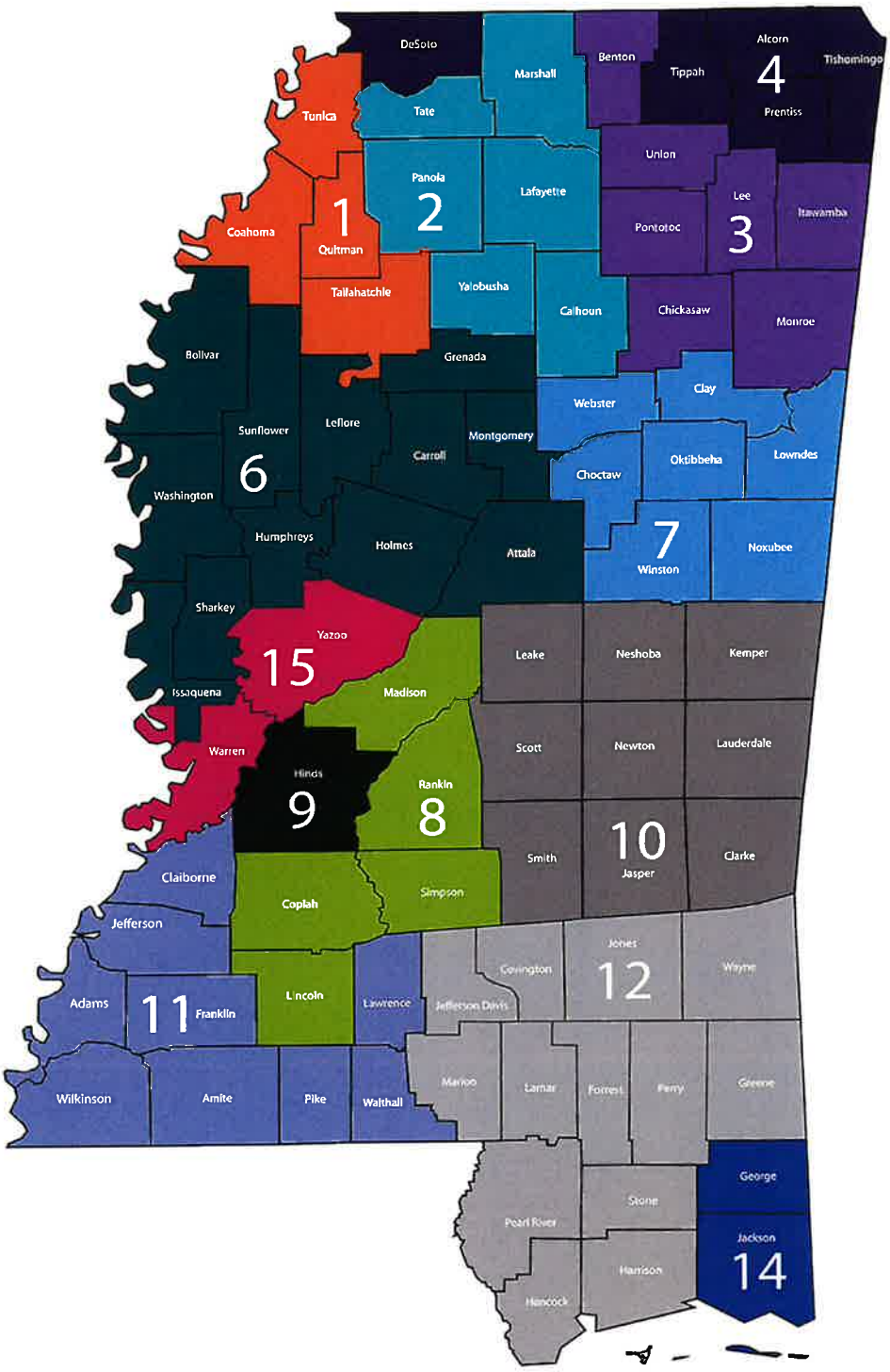
(6) On or before November 1, 2023, the study commission shall prepare and submit a written report of its findings and recommendations to the Mississippi Legislature and the Office of the Governor, together with any proposed legislation necessary to implement its recommendations.

(7) Upon presentation of its report, the study commission shall be dissolved.

SECTION 4. This act shall take effect and be in force from and after July 1, 2022.

Appendix B

Map of CMHC Regions in Mississippi


DeSoto
Marshall
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Tippah
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Prentiss
Tunica
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Itawamba
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Wilkinson
Amite
Pike
Walthall
Marion
Lamar
Forrest
Perry
Greene
George
Stone
Pearl River
Jackson
14
Harrison
Hancock

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